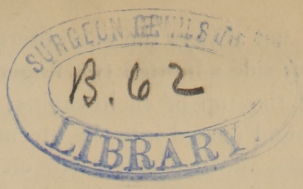

CASES OF DOUBLE UTERUS AND VAGINA.[1]

BY JAMES R. CHADWICK, M. D.

CASE I. *Uterus and Vagina Double Throughout.* — On March 3, 1876, Mrs. B., of Irish parentage, forty years of age, married for twenty-six years, having had no children, but one miscarriage two years before, applied at my Dispensary for the relief of painful coition, dating from the time of marriage. Menstruation had appeared at the age of thirteen years, and had recurred regularly every fifteen days, with some pain and moderate flow. There was a steady backache.

Digital examination traced the dyspareunia to a tense, unruptured hymen, which barely admitted two fingers. Inspection of the genitals, with a view to relieving this condition by incision of the fibrous band, disclosed a second opening to the right of the other one, which allowed the passage of a single finger only. The two vaginal canals were separated throughout by a thick septum. Each vagina had an os at its extremity belonging to a common collum uteri. Owing to want of time and the promise of a second visit on the part of the patient no exploration of the uterine cavity was made, but I have reason to suppose that the double uterus was similar to that in the next case. The patient never returned.

This case is of interest as showing the cause of the fibrous unruptured hymen to which the symptoms were attributable.

CASE II. *Uterus and Vagina Double Throughout.* — Mrs. L. H., twenty-two years of age, one year married, applied at my Dispensary on May 2, 1877. She had had no children or miscarriages; had menstruated regularly from the age of fifteen years, with much flow, lasting four days, but very little pain. Last winter she had had a slight attack of pelvic inflammation, which had confined her to bed for a week. She sought treatment for a yellowish discharge from the vagina and for constipation.

On digital examination a thick vertical septum was found dividing the vagina in its median line; this took its rise from the vaginal wall anteriorly one half inch behind the urinary meatus, and posteriorly one inch above the fourchette; it seemed as though the latter insertion had been partially torn off at the first attempt at coitus. The right vagina was more developed than the left, and seemed to have been generally

[1] Read before the Obstetrical Society of Boston.

if not always the one entered by the male organ. The hymen on the left side admitted two fingers, but bound them tightly. An os was felt at the top of each vagina, belonging to a common collum uteri. A sound passed into the uterus to the depth of two inches on the right side, and two and a half on the left; the two sounds then lay side by side, but could not be made to touch each other; while they were in position the left hand could be made to grasp the common fundus through the abdomen and thus determine positively that the malformation was of that variety known as *uterus septus duplex.* To the right of the uterus was a small ill-defined rounded body, distinct from the fundus, which was probably the remains of an old pelvic effusion.

A vaginal douche and a laxative relieved all the symptoms at the end of a week, since which time the patient has not been seen.

These two cases are illustrations of the simplest forms of duplicity in the female genital organs due to arrest of development during the embryonic period. The apposed walls of the two Müller's ducts, from which the genital tract is formed, fail to fuse, and disappear, but remain as a firm septum.

In the next two cases there was the same persistence of the septum, formed of the apposed walls, together with a failure of one side to establish an external opening.

Case III. *Double Uterus and Vagina; Atresia of the Left Side.* — This case was seen in consultation with Dr. J. L. Sullivan, of Malden, whose report I quote in full.[1]

"Nellie D., resident of East Cambridge, seventeen years old last January, of Irish parentage, light complexion, good constitution, childhood healthy.

"On July 4, 1874, in the fifteenth year of her age, the catamenia appeared for the first time, without pain; color and quantity normal. She menstruated regularly until November of the same year, when the flow was scanty and attended with moderate pain. These symptoms were attributed to 'taking cold.' In January, 1875, she missed her period. In February menstruation was reëstablished, this time easy and natural. In March she experienced severe dragging pains, referred chiefly to the back, and voided per vaginam a good deal of fluid blood and several coagula. In April the catamenia were replaced by an offensive purulent discharge. This discharge returned at irregular intervals, and was sometimes tinged with blood. The family physician was now called; opiates were prescribed, a specialist was summoned in consultation, but no exact diagnosis could be established. In August, 1875, the patient suffered an aggravation of all the distressing symptoms; a much larger quantity than usual of fœtid pus escaped from the vagina, accompanied by agonizing pains resembling those of abortion. From this time until

[1] Bost. Med. and Surg. Journ., December 13, 1877.

September, 1876, the discharge was continuous, but during the whole period (thirteen months) there was no admixture of blood. From the latter date until February, 1877, an occasional tinge of blood was noticed; from February to June none.

"During this long period of menstrual irregularity and recurring uterine irritation it is worthy of note that there were no symptoms referable to the bladder or urethra, nor any, so far as could be learned, which pointed distinctly to inflammation of any of the pelvic organs or tissues. The general health suffered; the girl grew thin and pale and lost strength, and the appetite became capricious. The bowels were confined rather than loose, owing probably to the opiates to which she was obliged to have recourse. Aside from the pain and purulent discharge there were no other special symptoms noted.

"Such were the particulars gathered on my first visit, June 5th. Temperature normal, pulse rather quick and feeble (pulse of irritation). Placing the patient on her back with the abdomen uncovered, I thought I observed an unusual fullness of the hypogastrium. On palpation there was a feeling of tension and resistance throughout that region, but no decided fluctuation. The percussion note was flat. The bladder, explored by the catheter, was found to be of normal size and not particularly sensitive, although displaced considerably to the left of the median line. On examining per vaginam, the patient being in the left lateral position, I detected a large, elastic swelling or tumor, situated in front of the vagina between it and the bladder (which it seemed to have pushed to one side), and extending upwards towards the umbilicus. My attention was next arrested by the discovery of a minute perforation of the anterior vaginal wall, situated in the median line, about an inch behind the meatus urinarius, and apparently communicating with the interior of the tumor. Into this aperture I succeeded in inserting a uterine probe, and passing it thence upwards and forwards until its further advance was checked by the handle. The instrument could be moved freely in every direction, and had evidently entered a cavity of no small size. On withdrawal it was found smeared with fœtid pus. It now seemed clear that the case was one either of chronic abscess or of double vagina; if the latter, the anterior division or channel must have been congenitally closed with the exception of the minute opening described, or have been occluded subsequent to birth, and was now probably distended with retained menstrual secretions in a state of decomposition. I next sought for the portio vaginalis and fundus vaginæ, but the attempt failed on account of what seemed to be an elongation of the vagina, as if it had been stretched or drawn up beyond the reach of the finger, carrying with it the uterus. Being now satisfied that, whatever might be the nature of the swelling, a free incision and evacuation of its contents were required, I so informed the patient's friends, and in

view of the possible dangers of the operation asked and obtained permission to secure Dr. Chadwick's assistance. Three days later, June 8th, the patient being etherized, a second and more thorough examination, digital and with the speculum, was made by both Dr. Chadwick and myself. Thanks to the anæsthetic, it was now possible to reach with the finger the vaginal cul-de-sac, and to distinguish at its summit a small orifice resembling an os uteri, into which a sound penetrated to the depth of half an inch. It was not, however, found possible to bring this orifice into view with the speculum, nor could any collum uteri be made out. The tumor was now incised by Dr. Chadwick, a director having been first thrust through the perforation already described as existing in the anterior vaginal septum ; the latter was cautiously divided by a blunt-pointed bistoury carried upwards to within two inches of the supposed mouth of the womb. About a pint and a half of very offensive fluid of a dirty-green color escaped per vaginam. On exploring with the finger the cavity just laid open it proved to be a second vagina, largely dilated, and having an opening at its summit similar to that of its fellow, through which the sound passed into a second cavity nearly as deep as the first, and was thence pushed upwards until its extremity could be felt through the abdominal walls at a point a little to the right of the median line, two inches above the umbilicus. This cavity was believed to be that of the uterus, distended by the gradual accumulation of its own secretions and its abortive efforts to expel them, and so it proved. Very little hæmorrhage followed the incision, the compressed and condensed tissues divided being indisposed to bleed. After thoroughly syringing the parts with carbolized warm water the patient was left to recover. Her subsequent course was all that could be wished. The after-treatment consisted in cleanliness merely, disinfecting injections being repeated thrice daily. On the 17th of June, no unfavorable symptoms whatever having occurred, she was again etherized, and the two vaginæ thrown completely into one by prolonging the original incision nearly to the os or rather ora uteri, for it was now plain that there were two. There was no hæmorrhage. A week later the patient was sitting up, and soon began to move about.

" July 5th the menses appeared without pain, in every respect normal. August 5th, has been weighed, and found to have gained fourteen pounds ; looks plump and well. Four weeks ago she was reëxamined by Dr. Chadwick and myself. We found one vagina, not much larger than normal, traversed at its summit by a vertical septum running obliquely from before backwards so as to form a double cul-de-sac with an os uteri debouching on each side, with hardly a trace of a cervix. A sound introduced into the right os, which had on a former occasion proved nearly impervious, penetrated to the depth of about two inches ; a second, introduced into the left os, the other instrument being retained *in situ*,

penetrated to the depth of two and one half inches. The contact of the sounds with each other was prevented by an intervening septum, dividing both the uterus and cervical canal into two separate, non-communicating cavities or cornua. The failure of the attempt before mentioned to explore with the probe the right uterine chamber, or that opening into the unclosed vaginal division or channel, may be explained by supposing that portion of the organ to have been compressed and its cavity temporarily obliterated by the distended left or opposite segment. From the suppression for successive months at a time of any sanguineous vaginal discharge, alternating with the transient appearance of blood mingled with the puriform secretion, amenorrhœa of the compressed cornu, or chamber, may be inferred, with partial reëstablishment of its functions at irregular intervals.

"The above affords a good example of the first or simplest variety of so-called double uterus and vagina, uterus bicornis or bilocularis, in which the fissure is perfect, that is in which the septum descends to the external orifice, divides the latter, extends to the vagina, reaches as far as the pudenda, in the virginal state dividing the hymen, and forms a separate vagina for each half of the uterus. (Rokitansky.) The present case is interesting, first, from its being a rare form of congenital malformation; second, from the almost complete occlusion of one of the vaginal divisions and the train of unpleasant symptoms to which soon after the establishment of menstruation this condition gave rise. The interest is heightened by the difficulty experienced in forming an exact diagnosis during the early stage, before the development of any appreciable swelling or tumor that could direct attention to the real nature of the case. Later, when I saw the patient, the question of diagnosis had narrowed itself to the differentiation of double vagina from chronic abscess, the chief points of distinction being, first, absence of general symptoms denoting serious inflammatory action and of the facial expression characteristic of long-continued, copious suppuration; second, failure to discover local thickening or induration of the tissues, — anything, in short, like the walls of an abscess or pus-secreting cavity."

Case IV. *Uterus Duplex Bicornis; Double Vagina with Atresia of the Right Side.* — Mrs. W., of American parentage, applied at my Dispensary on August 13, 1877. She was twenty-one years of age, had had no children or miscarriages, having been married but three months. Menstruation began six months after her seventeenth birthday, and had since recurred without intermission every three and a half to four weeks; the flow had generally lasted seven days, but was scant and attended by much pain. A white, offensive discharge from the vagina had persisted for most of the period since the establishment of menstruation; there had likewise been constant pain in the back, genitals, and right hip. Marriage had produced no change in the symptoms, — a suggestive circumstance.

The patient was emaciated and bore the marks of protracted suffering on her face and in the deranged condition of the nervous system.

A digital examination revealed a rather narrow vagina, a uterus of normal size lying in the hollow of the sacrum, but freely movable. Along the right side of the vagina could just be detected a circumscribed elastic resistance extending from the cervix to the right pubic ramus. Through the speculum no encroachment upon the vaginal canal was perceptible, but a minute opening in the vaginal wall was disclosed half an inch anterior to the os uteri in the median line; through this aperture pressure on the elastic body caused a most fœtid pus to exude.

The whitish discharge was thus tracked to a cavity lying alongside the vagina, the peculiarities of which led me to suspect an occluded second vagina. I accordingly sent her to the City Hospital for operation, with a guarded expression of opinion to that effect.

A few days later Dr. O. W. Doe, to whose ward she was assigned, inserted a much-curved wire probe through the opening, and cut down upon its point through the vaginal wall just behind the right pubic ramus. Less than an ounce of pus was evacuated, and the incision was carried back nearly to the collum uteri. The cavity could be traced along the collum for half an inch, but no further passage was then detected. Despite the failure to obtain corroboration of the diagnosis my conviction of its accuracy was not shaken.

A week later, in wiping out the cavity with cotton, I brought out a string of mucus which was attached to the uppermost extremity of the cavity. This, I argued, would have been free had it not come from a still undiscovered second cervical canal. A few days subsequently Dr. Doe was able to pass a sound two and a half inches into a uterine canal from the suppurating cavity. The only treatment had been disinfectant vaginal injections.

A month later the patient presented herself at my Dispensary, when I fully confirmed the existence of a second uterine cavity. The sound entered on the left side of the uterus directly upwards, while at the same time a sound in the right side passed directly to the right. Between the points of the two the left hand could depress the abdominal wall, thereby demonstrating that the cavities were contained in two separate horns of the uterus.

Suppuration had ceased, and the patient was rapidly regaining health, strength, and freedom from pain, which she had not had since girlhood.

The two last cases are chiefly of interest in the way of diagnosis. In each instance this was based, in my mind, upon the coincidence of the commencement of the symptoms with the establishment of the menstrual function; the long duration and the extremely offensive character of the discharge (in Dr. Sullivan's patient the odor was so bad as

to prevent attendance at school, and any association with other girls); the absence of induration and fixation of the surrounding tissues, such as certainly would have been apparent had the suppuration been a result of peritonitic or cellulitic inflammation; and finally the fact that there is usually no natural cavity in this position — except the bladder, which was proved healthy — that could become the seat of a suppurative inflammation.

The indications were unequivocal. The danger of septicæmia, which proves fatal after so many operations for the evacuation of retained menstrual blood, may have been lessened by the years of suppuration, but was probably averted, in great measure, by the thorough cleansing of the cavity with a disinfectant fluid immediately after the operation and for several weeks subsequently.

Case V. *Vaginal Septum.* — On October 29, 1877, Mrs. F., twenty-six years of age, married for five years, was brought to my Dispensary for examination by Dr. W. P. Brechin, who had discovered a year and a half previously a vaginal septum. The patient had menstruated regularly and profusely since the age of eight years and two months, when rape was committed upon her by a man who was convicted for the offense, and is now serving a life sentence in the State's prison. She had had one male child, weighing six pounds, born seven years before. No miscarriages.

On examination a fold of mucous membrane was found to be hanging from the vaginal wall just behind the urinary meatus. This, Dr. Brechin stated, had, when last seen, an attachment to the posterior vaginal wall, thus forming a septum three quarters of an inch in width, dividing in two the vaginal entrance. The vaginal canal above the septum had been single. The patient asserted that the male organ sometimes entered one side and sometimes the other.

That this septum was congenital I cannot affirm, for it is quite possible that it should have resulted from the abnormal healing of the hymen and vaginal entrance, which were very extensively torn at the time of the rape.

It is certainly curious that the septum should not have given way during the birth of the child, and yet been broken down subsequently by coition.

The uterus was single and normal.